

**Affected Programs:** BadgerCare Plus, Medicaid

**To:** Medical Equipment Vendors, Pharmacies, Physician Clinics, Physicians, HMOs and Other Managed Care Programs

## New Prior Authorization Criteria for Bone Growth Stimulators

This *ForwardHealth Update* introduces new prior authorization (PA) criteria for bone growth stimulators, effective for PA requests received on and after July 1, 2015.

### General Coverage Information

Bone growth stimulators are currently covered by ForwardHealth with prior authorization (PA). This *ForwardHealth Update* introduces new PA criteria for bone growth stimulators, effective for PA requests received on and after July 1, 2015.

### Prior Authorization Approval Criteria

Bone growth stimulators are considered Class III medical devices by the Food and Drug Administration (FDA). Prior authorization requests for these devices may be approved if they are medically necessary and are employed for a qualifying FDA-approved use. As stated in DHS 107.02(2m) and 107.24(2)(a), Wis. Admin. Code, a physician's prescription is required. A copy must be included with each PA request. Refer to the Durable Medical Equipment (DME) Index on the Provider-specific Resources page for Individual Medical Supply Providers in the Providers area of the ForwardHealth Portal at [www.forwardhealth.wi.gov/](http://www.forwardhealth.wi.gov/) for more information about place of service codes, device life expectancies, and maximum allowable fees.

### **Electrical Bone Growth Stimulators**

Documentation of *at least one* of the following clinical criteria must be submitted for PA approval of an electrical bone growth stimulator using Healthcare Common Procedure Coding System (HCPCS) procedure code E0747 (Osteogenesis stimulator, electrical, non-invasive, other than spinal applications):

- A nonunion fracture of bones of the appendicular skeleton (clavicle, humerus, radius, ulna, femur, fibula, tibia, carpal, metacarpal, tarsal, or metatarsal) demonstrating three or more months of ceased healing. Serial radiographs must include two sets of radiographs, each with multiple views of the fracture site and separated by a minimum of 90 days.
- A failed fusion of a joint where a minimum of nine months has lapsed since the last surgery.
- Congenital pseudarthrosis.

Documentation of *at least one* of the following clinical criteria must be submitted for PA approval of an electrical bone growth stimulator using HCPCS procedure code E0748 (Osteogenesis stimulator, electrical, non-invasive, spinal applications):

- Spinal fusion surgery for members with a history of previously failed spinal fusion at the same site.
- Multiple level fusion surgery involving three or more vertebrae (e.g., L3-L5, L4-S1).
- A failed fusion where a minimum of nine months has lapsed since the last surgery.

### ***Ultrasonic Bone Growth Stimulator***

Documentation supporting the use of an ultrasonic bone growth stimulator for the treatment of nonunion fracture of bones of the appendicular skeleton (clavicle, humerus, radius, ulna, femur, fibula, tibia, carpal, metacarpal, tarsal, or metatarsal) must be submitted for PA approval of an ultrasonic bone growth stimulator using HCPCS procedure code E0760 (Osteogenesis stimulator, low intensity ultrasound, non-invasive). Nonunion fractures must be documented by a minimum of two sets of radiographs (with multiple views) obtained prior to starting treatment and separated by a minimum of 90 days.

### **Noncovered Indications**

Bone growth stimulators are not covered for any of the following conditions:

- Nonunion of skull, vertebrae, or tumor-related fracture.
- Delayed fracture.

### **Prior Authorization Documentation**

All of the following must be included as part of a PA request for a bone growth stimulator:

- A completed Prior Authorization Request Form (PA/RF), F-11018 (05/13).
- A completed Prior Authorization/Durable Medical Equipment Attachment (PA/DMEA), F-11030 (07/12).
- Documentation supporting the criteria in the Prior Authorization Approval Criteria section of this *Update*.
- A physician's prescription.

### **Information Regarding Managed Care Organizations**

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. For managed care policy, contact the appropriate managed care organization. Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin AIDS Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at [www.forwardhealth.wi.gov/](http://www.forwardhealth.wi.gov/).

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